GLOSSARY OF HEALTH CARE TERMS
Developed by FamiliesUSA

209(b) - A section of the 1972 Social Security amendments that allows states to have more restrictive Medicaid financial standards than the SSI program for adults who are aged, blind, or disabled.

Adjusted Community Rate (ACR) is an HMO's estimate of the premium it would charge to Medicare beneficiaries if these beneficiaries were enrolled as commercial enrollees and not covered by Medicare. The ACR is intended to gauge the appropriateness of reimbursements to plans by the Centers for Medicare and Medicaid Services (CMS). If the CMS payment is higher than a plan's ACR, the plan is required by law to provide the difference to Medicare enrollees through lower premiums or higher benefits or to return it to the Medicare program *(see also Medicare+Choice).*

Adverse Selection – When a health plan or program attracts members who are sicker than the general population (see also *Risk-Selection*).

American Association of Health Plans (AAHP) - The trade organization that represents managed care organizations (HMOs and PPOs).

Any Willing Provider (AWP) Legislation - State law that requires a Managed Care Organization (MCO) to accept any provider willing to meet the terms and conditions in the MCO's contract, whether or not the MCO wants or needs that provider.

Approved Charge - (*see Medicare Part B Provider Payment*)

Assignment - (*see Medicare Part B Provider Payment*)

Average Manufacturer Price (AMP) - The price at which drugs are sold by the manufacturer to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts. For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

Average Wholesale Price (AWP) - The AWP is the price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies.

Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or governments, meaning that those customers pay significantly less than the AWP.

Balance Billing - (*see Medicare Part B*)

Balanced Budget Act of 1997 (BBA) - 1) created the Children's Health Insurance Program, which expanded coverage to poor children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice, which includes an array of private health plan options among which beneficiaries may choose; 3) gave states greater authority to structure their Medicaid programs, including the authority to mandatorily enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

Beneficiary - A person who receives benefits. The term is commonly applied to anyone receiving benefits under Medicare or Medicaid programs or covered under a private health insurance plan.

Benefit Cap - A dollar limit placed on the assistance that can be provided to an individual in a given time period, which is usually one year.

Benefit Package - A group of guaranteed services provided by a health plan to its members.

Bulk-Purchasing Programs - Single or multi-state programs that combine various groups or programs—such as state employees, the Medicaid program, the pharmacy assistance program—to create a larger group that can negotiate better drug prices from manufacturers. Bulk-purchasing programs may include people without prescription drug insurance.

Capitation or Capitated Payment - (*see Managed Care Reimbursement*) **Carrier** - A private organization, usually an insurance company, that has a contract with the Centers for Medicare and Medicaid Services to process claims under Part B of Medicare.

Carve-Out - A set of Medicaid services (such as behavioral health services) or a population (such as people with HIV or children with special needs) not required to enroll in a Medicaid managed care program. These services or populations are said to be "carved out" and provided separately, either in fee-for-service or through a separate managed care organization.

Case Management - A process for individuals with specific health care needs in which a plan is formulated and implemented that uses health care resources in a cost-effective manner to achieve optimum patient outcome.

Categorically Needy - Medicaid eligibility based on defined indicators of financial need of people in specific categories: families with children, pregnant women, and people who are blind, disabled, or over 65. People who do not fall into these categories cannot qualify for Medicaid, no matter how low their incomes (unless a state has obtained a federal Section 1115 waiver to include additional groups).

Centers for Medicare and Medicaid Services (CMS) - CMS is the new name for the agency within the U. S. Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. Formerly known as the Health Care Financing Administration (HCFA).

CHIP - (see *State Children's Health Insurance Program*)

Closed Panel - (*see Health Maintenance Organization*)

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985. A provision of this federal law requires that certain employers permit laid-off workers and their dependants to remain in the employee health plan for a specified period of time. Employees must pay the full cost of the premium (including the share formerly paid by the employer).

Co-Insurance - The portion of covered health care expenses that must be paid, in addition to the deductible, by the health plan members. The figure is usually expressed in a ratio, such as 80/20, where the insurer pays 80 percent and the client pays the remaining 20 percent of the bill (see *Cost-Sharing*).

Community Rating - A method of determining premiums for financing health care in which the premium or capitation rate is based on the average cost of health services used by all customers in a specific service area. Community rating is required of federally qualified HMOs and by many states.

An HMO must obtain the same amount of money per member for all members in the plan.

Community rating does not permit HMOs to adjust rates for differences in age, gender, average contract size, and industry factors.

Concurrent Review - (see *Utilization Review*)

Consumer Price Index (CPI) - A measurement of inflation at the consumer level. Many state programs use the CPI as a measure of changes in consumer buying power and increase the level of benefit provided through pharmacy assistance programs to reflect those changes. The Bureau of Labor Statistics within the U.S. Department of Labor tracks the CPI.

Cost-Sharing - A health insurance policy provision that requires an insured party to pay a portion of the costs of covered services.

Copayment - The amount a plan member has to pay each time he or she sees a doctor, fills a prescription, or receives other medical services. For example, some states require Medicaid beneficiaries to pay $1 for each physician office visit or each prescription drug.

Deductible - A set dollar amount that must be paid *before insurance coverage begins*. For example, many private insurance policies require payment of $100 or $200 out-of-pocket before the insurance will pay all or part of a medical bill. Medicare requires the payment of a $100 deductible of each year for outpatient services.

Credentialing - A process of review used to approve a provider who applies to participate in a health plan. Specific criteria and prerequisites are applied in determining initial and ongoing participation in the health plan.

Deductible - (see *Cost-Sharing*)

Diagnosis-Related Groups (DRGs) - (*see Medicare Hospital Payment*)

Disenrollment - The process of voluntary or involuntary termination of coverage. When a health plan member quits because he or she prefers to leave, it is considered to be voluntary termination.

Involuntary termination includes members leaving plans because they switch jobs or members whose coverage is terminated by the plan against the members' will.

Dispensing Fee - A transaction fee that pharmacists charge to process and fill a prescription.

Disproportionate Share Hospital (DSH) Adjustment – pronounced "dish" (*see Medicare Hospital Payment*)

Drug Treatment Protocols - Documents that outline the clinical decision-making processes related to prescribing drugs. Protocols typically include a detailed clinical decision-making tree and generally recommend initiating therapy with the lowest-cost alternative.

Drug Utilization Review (DUR) - Review of physician prescribing, typically used to control costs and monitor quality of care. DUR programs are based on prescribing information collected electronically. They can be used prospectively to alert pharmacists when a patient might be taking drugs that could adversely interact. They can be used retrospectively to review physician prescribing practices.

Dual Eligible - A Medicare beneficiary who also receives Medicaid.

Early and Periodic Screening, Diagnosis, and Treat-ment Program (EPSDT) - Mandatory Medicaid benefits and services for children and adolescents under age 21 covered by Medicaid; designed to ensure children's access to early and comprehensive preventive health care and treatment. State Medicaid programs are required to provide EPSDT benefits.

End-Stage Renal Disease (ESRD) - Kidney disease that is severe enough to require lifetime dialysis or a kidney transplant. People who have ESRD are eligible for Medicare.

ERISA – The Employee Retirement Income Security Act of 1974 is a federal law governing employee benefit programs. For health insurance, ERISA includes general protections about benefits and disclosure of information to employees in the plan. ERISA also prevents states from regulating health insurance if the employer "self insures." Because self-insured programs are not under the jurisdiction of state insurance regulations, businesses can limit benefit packages.

Exclusive Provider Organization (EPO) - A type of preferred provider organization in which the patient is required to use the provider network and no coverage is available for out-of-network services.

Experience Rating – The practice by insurance companies of setting premium rates based on the actual claims experience of the group purchasing the plan.

Fail First – An approach to managed drug use and costs that requires that less aggressive (and often lower-cost) therapies be tried first and fail, before more aggressive (and often more expensive) therapies will be covered.

Federal Poverty Level - Guidelines established by the U.S. Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and nonfederal programs. Federal poverty thresholds vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia). In 2002, in the contiguous United States, the federal poverty level is $8,860 for an individual and $11,940 for a family of two.

Federally Qualified HMO - An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health service delivery information, utilization review and quality assurance, grievance procedures, financial status, and marketing information as specified in Title XIII of the Public Health Service Act.

Federal Supply Schedule (FSS) - The price available to all federal government purchasers. FSS prices are intended to equal or better the prices manufacturers charge their "most favored" nonfederal customers under comparable terms.

Fee-for-Service (or **Indemnity**) **Insurance** - Health insurance plans that reimburse physicians and hospitals for each individual service they provide. These plans allow clients to choose any physician or hospital. Managed care is an alternative to fee-for-service medicine.

Fiscal Intermediary - A private organization, usually an insurance company, that has a contract with the Centers for Medicare and Medicaid Services to process claims under Part A of Medicare.

Formulary - A list of drugs covered by a health plan or pharmacy assistance program. In some cases, the payers will only cover formulary drugs.

More commonly, non-formulary drugs are available to consumers, but the consumer must pay a higher copayment (see"Tiered Formulary").

Freedom of Choice - A Medicaid provision that requires states to allow beneficiaries the freedom to choose providers. States can seek Section 1915 and 1115 waivers of the freedom-of-choice requirement.

Gatekeeper Physician - A primary care physician who controls the access of his or her HMO patients to specialty medical care.

Generic Drug - A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms.

Generic drugs are FDA reviewed and must be bioequivalent, that is, they must have the same active ingredients and be absorbed by the body the same way as the brand-name counterpart.

Generic Substitution – A requirement, imposed by the payer (for the purpose of determining what drugs will be covered) that generic drugs, when available, be substituted for brand-name drugs unless the prescribing physician indicates in writing that the brand-name drug is required.

OR: **Generic Substitution** – (1) An insurance company requirement that generic drugs, when available, be substituted for brand-name drugs unless the prescribing physician indicates in writing that the brand-name drug is required. (2) A state law governing when and how pharmacists may substitute generic for brand-name drugs; these laws, which vary widely from state to state, specify what physicians must do if they want to ensure that a prescription is filled with a brand-name drug.

Grievance Procedure - Defined process in a health plan for consumers or health care providers to use when there is disagreement about a plan's services, billing, or general procedures.

Guaranteed Issue – A requirement (usually a state law) that insurers sell a policy to anyone who seeks one.

Guaranteed Renewal – A requirement that insurers renew the policies of policyholders. Used to prevent insurers from dropping policyholders who become ill and submit high claims.

Guidelines - Systematic sets of rules for choosing among alternate drug therapies. *Treatment* guidelines, or protocols, generally require that the drug therapy with the fewest side effects (often the oldest and cheapest therapy) be tried *(see also Fail First*), before more potent therapies are recommended. *Administrative* guidelines generally focus more on cost and may require that the least expensive therapy be used first; only if that fails should more expensive therapies be used.

Health Care Financing Administration (HCFA) – (*see Centers for Medicare and Medicaid Services*)

Health Insurance Flexibility and Accountability (HIFA) Initiative – (*see Waivers*)

Health Insurance Portability and Accountability Act (HIPAA) – A federal law to help workers maintain coverage when they change jobs. Limits the ability of plans to refuse to pay for "preexisting conditions."

Health Maintenance Organization (HMO) - A type of managed care health plan that provides, offers, or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. Covered services are usually paid for in full, sometimes with a nominal flat dollar copayment for office visits or other benefits, such as prescription drugs. There are several different models of HMOs:

- **Closed Panel** - A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients for other managed care organizations. Staff and group model HMOs *(see below)* are examples of closed panel HMOs.
- **Group Model** - The HMO contracts with a (multi-specialty) group of physicians that provide coordinated medical care for a fixed, prepaid member fee. Usually, the HMO pays the group a capitation for the enrollees who receive care through the group. A group of physicians will often care for members of several HMOs, but they cannot treat non- HMO members.
- **Individual (or Independent) Practice Association Model (IPA)** - HMOs contract with a group of physicians who work in their own offices. The HMO pays the IPA on a capitation basis. The IPA, in turn, pays the participating physicians, either on a capitation, fee schedule, or fee-for-service basis. These physicians may treat both HMO and non- HMO patients. The IPA may contract with more than one HMO.
- **Mixed Model** - A mixed model combines one model, such as a staff model, and another model, such as an IPA or a network. Mixed Models often result when HMOs expand either their capacity or geographic area.
- **Network Model** - The HMO contracts with two or more independent physician groups that provide general and specialty care. Typically, these groups are paid on a capitation basis. Network physicians may treat HMO as well as non-HMO patients. (Similar to the group model, except physicians who work within the network model can treat non-plan members.)
- **Staff Model** - Medical providers practice as a group in a facility owned or leased by the health plan. Physicians and other health care professionals are salaried employees.

Healthplan Employer Data Information Set (HEDIS) - An ever-evolving set of data-reporting standards for determining the quality of a health plan's services and health outcomes. HEDIS is designed to provide some standardization in performance reporting for financial, utilization, membership, and clinical data so that employers and government purchasers can compare performances among health care plans. HEDIS is a product of the National Committee for Quality Assurance (NCQA).

HIFA - *(see Health Insurance Flexibility)*

HIPAA - *(see Health Insurance Portability)*

Hospice - A public or private organization that provides pain relief, symptom management, and supportive services to people with a terminal illness. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for a terminal illness.

Hospital Insurance (HI) (also known as Medicare Part A) - The Medicare program that covers the cost of hospital and related post-hospital services (see *Medicare Part A*).

Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) - A not-forprofit organization that performs accreditation reviews primarily on hospitals, other institutional facilities, and outpatient facilities. JCAHO also accredits HMOs.

Katie Beckett Provision - Katie Beckett was a ventilator-dependent, institutionalized child who was unable to go home, not because of medical reasons, but because she would no longer have been eligible for Medicaid because of her parents' income. Medicaid's Katie Beckett provision extends Medicaid coverage to certain disabled children living at home who are under 18 years old and who would be eligible for Medicaid if they were staying in a hospital or nursing facility.

Managed Care Organization (MCO) - A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and directs use of medical care services.

Managed Care Reimbursement -- Managed care organizations pay their contracting providers in a variety of ways, often combining one or more of the payment method listed below:

- **Bonus** - a payment to a physician or physician group beyond any salary, fee-for-service payment, capitation, or returned withhold.
- **Capitation or Capitated Payment** - A health insurance payment mechanism in which a fixed amount is paid per person to cover services; a fixed, per capita payment.
    - Capitation amounts are usually expressed in units of per member per month (PMPM).
    - Capitation may be used by purchasers to pay health plans or by plans to pay providers.
- **Fee-For-Service** - The traditional health care payment system under which physicians and other providers receive a payment that does not exceed their billed charges for each unit of service provided.
- **Withhold** - A percentage of payments or set dollar amounts that an organization deducts from a physician's fee, capitation, or salary payment that may or may not be returned to the physician, depending on specific predetermined factors.

Medicaid - The federal entitlement health insurance program established in 1965 through Title XIX of the Social Security Act. Medicaid pays for health services for low-income Americans under 65 and nursing home care for impoverished older adults over 65. It is financed through federal and state funds; the amount allocated to Medicaid varies by state, and each state implements its own Medicaid program.

Medicaid Drug Rebate Program - Requires a drug manufacturer to enter into a national rebate agreement with the U.S Department of Health and Human Services before the government will pay for the manufacturer's outpatient drugs dispensed to Medicaid patients. The rebate formula requires that pharmaceutical manufacturers rebate to the states the greater of a) 15.1 percent of the average manufacturer price (AMP) to wholesalers for brand-name drugs, or b) the manufacturer's best price, which is the lowest

price offered to any other customer, excluding federal supply schedule prices and prices to state pharmacy assistance programs.

For generics, the rebate is 11 percent of AMP.

Medical Loss Ratio - The ratio of benefits paid out to premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars were paid out in benefits, while high loss ratios indicate that a high percentage of the premium dollars were paid out as benefits. Medical loss ratios are calculated as total medical expenses/total revenues.

Medical Savings Accounts (MSAs) – Highdeductible insurance plans where a plan's sponsor (e.g., the employer) pays the premium and makes monthly deposits to a medical savings account set up by the beneficiary. These accounts are taxexempt as long as withdrawals are used to pay for an individual's medical expenses. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created a demonstration project for MSAs for individuals under the age of 65.

Medicare currently has an MSA test program limited to 390,000 eligible beneficiaries.

Beneficiaries who enroll in MSAs are not protected by the balance billing requirements in the traditional fee-for-service Medicare program.

Medically Needy - An optional Medicaid category in which states can cover individuals and families whose incomes minus accumulated medical bills are below state income limits for the Medicaid program.

Medicare - The federal health insurance program established in 1965 through Title XVIII of the Social Security Act for Americans who are over 65, disabled, or diagnosed with end-stage renal disease.

Medicare Part A (*also known as Hospital Insurance*) - Medicare hospital insurance (HI) covers beneficiaries for inpatient hospital, home health, hospice, and limited skills nursing facilities. Eligibility is normally based on prior payment of payroll taxes.

Beneficiaries are responsible for an initial deductible each time they are ill and a copayment for some services.

Medicare Part B (*also known as Supplementary Medical Insurance*) - Medicare supplementary insurance (SMI) covers Medicare beneficiaries for physician services, medical supplies, and other outpatient treatment such as laboratory tests and x-rays.

Medicare beneficiaries must pay a monthly premium for Part B coverage.

Medicare Buy-In – *(see Qualified Individual–*1*; Qualified Medicare Beneficiary; and Specified Low–Income Medicare Beneficiary)*

Medicare+Choice – A new part of Medicare offering an array of private health plan options in addition to HMOs, including:

- **Provider Sponsored Organizations** (see Provider Sponsored Organization)
- **Preferred Provider Organizations** (see *Preferred Provider Organization*)
- **Medical Savings Accounts** (see *Medical Savings Accounts*)
- **Private Fee-for-Service Plans** (see *Private Fee-for-Service Plans*)
- **Medicare Hospital Payment Diagnosis-Related Groups (DRGs)** (*see Medicare Hospital Payment*) - A system for determining payments to hospitals used by Medicare and some other public and private payers. The DRG system classifies patients into groups based on the principal diagnosis and other relevant criteria. Hospitals are paid the same for each case classified in the same DRG, regardless of the actual cost of treatment. However, "outliers," cases with extremely long lengths of stay or extraordinarily high costs, receive extra payment.

Disproportionate Share Hospital (DSH) Adjustment - An additional payment through Medicaid and Medicare for hospitals that serve a relatively large volume of uninsured, Medicaid, and Medicare patients.

Limiting Charge - The maximum amount that a non-participating physician is permitted to charge a Medicare beneficiary for a service; in effect, a limit on balance billing. Starting in 1993, the limiting charge has been set at 115 percent of the Medicare-allowed charge.

Participating Physician - A physician who signs an agreement to accept assignment on all Medicare claims (*see Assignment*).

Resource-Based Relative Value Scale - An index that assigns weights to each medical service provided by physicians; the weights represent the relative amount paid for each service. To fix a fee, the index for a particular service is multiplied by a constant dollar amount. The Resource-Based Relative Value Scale is used for the Medicare physician fee schedule and consists of three cost components: physician work, practice expense, and malpractice expense.

Medicare Part B Provider Payments Allowed Charge - The amount Medicare approves for payment to a physician and other Part B providers. Typically, Medicare pays 80 percent of the approved charge and the Medicare beneficiary pays the remaining 20 percent.

Assignment - The process in which a provider agrees to accept a Medicare-approved charge as payment in full. Medicare's share of the cost of a service is paid directly ("assigned") to the provider. Typically Medicare pays 80 percent and the beneficiary pays 20 percent of the approved amount.

Balance Billing - The practice of billing patients in excess of the amount approved by the health plan. Under Medicare, the excess billing amount cannot be more than 15 percent over the approved charge.

Bonus Payment - An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare's 80 percent share of allowed charges.

Volume Performance Standard (VPS) - A method of adjusting Medicare reimbursement fees for physicians based on annual increases in Part B expenditures compared with predicted increases.

Medicare Reform - The terms and concepts below all figure in current discussions about changes in the Medicare program to ensure its long-term viability:

- **Defined Benefit** is a guarantee of certain benefits by a sponsor (e.g., an employer or the government), cost notwithstanding.
- **Defined Contribution** is a payment structure for a benefit plan in which a benefit sponsor (e.g., an employer or the government) pays a specified amount of a benefit's costs on behalf of each covered individual. The individual is responsible for charges above that defined amount.

Federal Employee Health Benefits Plan (FEHBP) is the health benefits plan for employees of the federal government. The Office of Personnel Management, which administers FEHBP, approves a variety of health benefits plans from which employees may choose. Each plan must offer similar core benefits and can offer additional benefits. The government pays no more than 75 percent of the cost of an employee's chosen plan and the employee pays the rest.

Premium Support Model is a type of health benefits plan in which the plan sponsor (e.g., an employer or the federal government) pays a defined share of a beneficiary's health plan premium and the individual pays the rest. The National Bipartisan Commission on the Future of Medicare considered shifting Medicare to a premium support model. That proposal is now embodied in legislation that has been introduced in Congress. The Federal Employee Health Benefits Plan is an example of a premium support health benefits plan.

Voucher is a payment worth a specific dollar amount given to an individual towards the purchase of a specific benefit.

Medicare Rx Discount Card - A Medicare drug discount program proposal offered by the Bush Administration. The program would be open to all Medicare beneficiaries and would be operated through multiple Pharmacy Benefit Managers (PBMs, see below), although beneficiaries could only enroll in one PBM's card program at a time.

Medigap (or Medicare Supplemental) Policy - A privately purchased insurance policy that supplements Medicare coverage. The policy must meet requirements set by federal statute and by the National Association of Insurance Commissioners.

Community-Rated Medigap Policies - Medigap policies that are community-rated, in which the insurer's premium is the same for everyone in a premium class within a specific geographic area.

Issue Age Medigap Policies - Policies in which an insurer's premium is based on the age of individuals when they first purchase health insurance coverage.

Attained Age Medigap Policies - Policies in which health insurance premiums are based on the current age of the beneficiary. Attained age premiums increase as the purchaser grows older.

National Committee for Quality Assurance (NCQA) - An independent, nonprofit organization that accredits HMOs and assesses and reports on health plan quality. The NCQA provides health plan information to consumers free of charge.

More than half the nation's HMOs participate in NCQA's voluntary accreditation and certification programs. NCQA also develops HEDIS standards.

Participating Physician (*see Medicare Physician Payment*)

Peer Review Organization (PRO) - An organization that contracts with the Centers for Medicare and Medicaid Services to investigate the quality of health care furnished to Medicare beneficiaries, to educate beneficiaries and medical providers, and to conduct a limited review of medical records and claims to evaluate the appropriateness of care provided.

Personal Needs Allowance (PNA) - The amount of an institutionalized Medicaid beneficiary's own money that can be set aside each month from Social Security and other retirement income sources to pay for personal incidentals. The minimum PNA is $30 per month/per individual.

Pharmacy Assistance Subsidy Programs – State funded programs that provide prescription drug insurance coverage. Most programs focus on low income seniors; some are opened to all Medicare beneficiaries. Generally, programs only cover individuals without any other drug insurance.

Pharmacy Assistance Discount Programs - State programs that give members a discount on prescription drug purchases. These programs do not insure individuals against the cost of drugs.

Pharmacy Benefit Managers (PBMs) - Companies that manage pharmacy benefits under contract on behalf of payers (e.g., state Medicaid or pharmacy assistance pro-grams, self-insured employers). PBMs can be stand-alone companies or a division of a larger insurance company, such as Aetna or Blue Cross. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

Pharmacy Plus Waiver – A demonstration program providing for a Section 1115 Medicaid waiver for pharmacy services only. These waivers can extend pharmacy services to Medicare beneficiaries with incomes up to 200 percent of the federal poverty level. The waiver must be "budget neutral," that is, the federal government's costs under the waiver cannot be greater than they would have been without the waiver.

Physician Hospital Organization (PHO) (*also known as Provider Service Networks*) - An organization formed by medical providers and one or more hospitals who establish integrated medical care delivery systems and contract directly with purchasers.

Point-of-Service Plans (POS) - A health plan that permits its enrollees, at the time services are needed, to decide whether to obtain covered services through designated "in-network" participating providers or through non-participating providers. Enrollees' cost-sharing responsibilities vary, depending on whether they obtain services through in-network or non-network providers. If using in-network services, the HMO's cost-sharing requirements (e.g., copayments for services) apply.

However, enrollees may seek non-network treatment and receive benefits on a fee-for-service basis, usually with substantially higher costsharing.

Pre-Certification – (see *Utilization Review*)

Preferred Provider Organizations (PPOs) - A managed fee-for-service product in which one can choose plan-selected providers who discount their fees. By visiting a PPO provider, a beneficiary will pay less money out-of-pocket for medical service than he or she would by visiting a non-PPO provider.

Premium - The charge, not including any required deductibles or copayments, for coverage under a health plan. Premiums are typically set in coverage classifications including individual, two-party and family, employee only, employee and spouse, employee and child, etc.

Premium Assistance – The use of federal funds for public health coverage programs—especially Medicaid and SCHIP—to purchase (or subsidize the purchase of) private insurance.

Primary Care Case Management (PCCM) - In Medicaid, a Section 1915(b) freedom-of-choice waiver program in which states contract directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid beneficiaries under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to their fee-for-service reimbursements.

Primary Care Physician – Generally, physicians who are internists, pediatricians, family physicians, general practitioners, and sometimes, obstetriciangynecologists.

Prior Authorization - A requirement that the payer give approval in advance before a particular drug or service will be covered.

Private Fee-For-Service Plans - Beneficiaries may choose a private insurance plan that accepts Medicare beneficiaries. Plans must offer all Medicare-covered services but may offer additional benefits. Plans decide how much to reimburse providers for services, and beneficiaries must pay the difference between this amount and Medicare's allowable provider charge.

Profiling - A pattern of practice, utilization (costs or services), or outcome (functional status, morbidity, or mortality) aggregated over time for a defined population of patients to compare with other practice patterns. HMOs often profile contracting physicians' practices to compare with one another.

Prospective Payment Assessment Commission (ProPAC) - An independent body established by Congress to advise on issues related to Medicare's hospital payment system.

Prospective Payment System (PPS) - The Medicare system used to pay hospitals for inpatient hospital services based on the Diagnosis-Related Group classification system.

Provider Sponsored Organizations (PSOs) - Organizations formed by providers, such as physician groups and hospitals, that contract directly with health benefit sponsors (e.g., government or employers) to provide health care services.

Qualified Individual-1 (QI-1) – Individuals eligible for Medicare Part A who have incomes between 120 and 135 percent of the federal poverty level and whose resources do not exceed twice the level allowed under SSI. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums for QI-1s. The program differs from SLMB *(see below)* because it is not an entitlement: There is a limit to the number of people who can enroll and beneficiaries have to reapply each year.

Qualified Medicare Beneficiary (QMB) – An individual eligible for Medicare Part A who has income at or below the federal poverty level and whose resources do not exceed twice the level allowed under SSI. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries.

Quality Assurance Plan - A formal set of managed care plan activities used to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

Resource-Based Relative Value Scale - (*see Medicare Part B Provider Payment*)

Risk Adjuster - A measure used to adjust payments made to a health plan on behalf of a group of enrollees in order to compensate for spending that is expected to be lower or higher than average, based on the health status or demographic characteristics of the enrollees.

Risk Pool - A defined account to which revenues and expenses are posted. A risk pool attempts to define expected claim liabilities and required funding to support such claims.

Risk Pooling - The process of combining risk for all groups into one risk pool.

Risk-Selection - Any situation in which health plans differ in the health risk associated with their enrollees because of enrollment choices made by the plans or enrollees. The problem of risk selection is especially troublesome in the Medicare HMO context. Currently, evidence suggests that Medicare HMOs enroll healthier Medicare beneficiaries, resulting in excess federal payments to this population. Without better risk-adjustment payments, Medicare HMOs will have incentives to either enroll healthier beneficiaries or to deny services to high-cost enrollees.

Section 1931 - The category of Medicaid that covers low-income families. Established in 1996 as part of the federal welfare reform law, Section 1931 provides Medicaid eligibility for families that, in the past, have been eligible for Medicaid as a result of their eligibility for the Aid to Families with Dependent Children (AFDC) program and for other families that meet income and resource limits established by states. Section 1931 also allows states to define income and resources in ways that, in effect, increase Medicaid eligibility levels for families.

Service Area - The geographic area serviced by a health plan, as approved by state regulatory agencies and/or detailed in a certificate of authority.

Social Security Disability Insurance (SSDI) - The portion of Social Security that pays monthly benefits to disabled workers under the age of 65 and their dependents. To be eligible for SSDI, individuals must have contributed a minimum of 40 quarters into the Security System. SSDI recipients (but not their dependents) automatically become eligible for Medicare after a two-year waiting period.

Specified Low-Income Medicare Beneficiary (SLMB) – *(pronounced "slim-bee")* An individual eligible for Medicare Part A who has income between 100 and 120 percent of the federal poverty level and whose resources do not exceed twice the level allowed under SSI. State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums for SLMBs.

Spend down - Individuals in 209(b) states or those eligible under a medically needy program must make payments on medical bills (or spend down) until their income in any given period, minus medical expenses, falls to or below the state prescribed income level to qualify for Medicaid.

State Children's Health Insurance Program (SCHIP) - The federal block grant program established in 1997 through Title XXI of the Social Security Act. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with income below 200 percent of the federal poverty level.

States can: (1) expand Medicaid to cover children at higher incomes, (2) create a new health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state's regular Medicaid program. Each state has a different SCHIP program.

Stop-Loss Insurance - A form of health insurance for a health plan or self-funded employer that provides protection from high medical expenses by covering all claims over a certain limit each year.

Supplementary Security Income (SSI) - A federal income support program for low-income disabled, aged, or blind individuals. Eligibility for the monthly cash payments does not depend on previous work or contributions to a trust fund.

Eligibility for SSI usually makes a person automatically eligible for Medicaid.

Supplementary Medical Insurance (*also known as Medicare Part B*) - The Medicare program that covers the cost of physician services, outpatient laboratory and x-ray tests, durable medical equipment, and outpatient hospital care (see *Medicare Part B*).

Title XVIII of the Social Security Act - The Medicare Statute.

Title XIX of the Social Security Act - The Medicaid Statute.

Transitional Medical Assistance (TMA) - Additional Medicaid coverage states must provide to families who would otherwise lose Medicaid because they have income over the eligibility limit.

Families who gain child support income should receive an additional four months of Medicaid coverage. Families who gain earned income should receive six or 12 months of additional coverage.

Families should also receive TMA if the eligibility limit for Medicaid is lowered, making them ineligible because they have income over the new limit.

Utilization Review (UR) - A formal review of patient utilization or of the appropriateness of health care services, on a prospective, concurrent, or retrospective basis.

Concurrent Review - Refers to management of health service use that takes place during the provision of services. Also, an assessment of a hospital stay, conducted by trained managed care staff via telephone or on-site visit, to ensure appropriate care, treatment, length of stay, discharge planning, and cost monitoring.

Prospective Review - The process of obtaining authorization, in advance, from the health plan for routine hospital admissions and other services. Often involves appropriateness review and assigned length of stay based on specified criteria. Failure to obtain preauthorization often results in financial penalty to either the patient or medical provider.

Retrospective Review - A method used to determine medical necessity and/or appropriate billing practices for services previously rendered.

Volume Performance Standard (VPS) - (see *Medicare Part B Provider Payments*).

Waivers Section 1115 Waiver - Section 1115 of the Social Security Act allows the Secretary of the U.S. Department of Health and Human Services to waive certain Medicaid requirements in order to allow states to establish demonstration projects that are "likely to further the goals of the Medicaid program." One goal is to provide health care to people with low incomes. States submit a waiver application to HHS, which must approve the application before the waiver can take effect.

Section 1915 (b) - A Section 1915(b) waiver allows states to waive Medicaid rules regarding freedom to choose a provider, establishment of statewide programs, and comparability of Medicaid benefits to different covered groups. Thus, states can require all or some categories of Medicaid beneficiaries to enroll in managed care either throughout the state or in limited geographical areas. Since passage of the Balanced Budget Act of 1997, states can mandate managed care enrollment for many Medicaid beneficiaries without a Section 1915(b) waiver. A state must still, however, obtain such a waiver to mandate managed care enrollment for children with special needs, persons who are eligible for both Medicaid and Medicare, and Native Americans.

Section 2176 *(also known as* 1915 *(c) or* 1915 *(d)*) - A Section 2176 waiver allows states to offer community-based long-term care services to Medicaid beneficiaries who would otherwise require nursing home care or other types of institutionalized care. Under this waiver, states provide a broad range of home and community-based services to people who are older than 65, developmentally disabled, or chronically ill. States must apply to the U.S.

Department of Health and Human Services for each specific program.

The Health Insurance Flexibility and Accountability (HIFA) Waiver - Policy guidance issued by the Bush Administration in August 2000 that provides for a fast-track approval process for Section 1115 Medicaid and SCHIP waivers. HIFA gives states new flexibility to cut benefits and increase cost sharing for some current beneficiaries. HIFA also requires states to include a private insurance component to their programs that would provide a Medicaid or SCHIP subsidy to individuals to purchase available employer sponsored or other private insurance instead of enrolling in the state's Medicaid or SCHIP program.

Therapeutic Substitution - Replacement of one drug with another drug from the same therapeutic class that the Food and Drug Administration (FDA) has determined to be "bio-equivalent" (same active ingredient with the same absorption rate). This includes substitution of one brand-name for another brand-name or substitution of a generic drug for a brand-name. Generally, this results in prescribing the less costly compound.

Tiered Formulary - Use of multiple copayment rates for formulary drugs, designed to encourage use of the least expensive alternative. Typically, tiered formularies have either two or three copayment tiers. A three-tiered formulary generally features a generic copayment, preferred brand copayment, and non-preferred brand or off formulary copayment.

Transitional Medical Assistance (TMA) – A federal program permitting low-income families to continue receiving Medicaid coverage for six or 12 months if they have earnings that raise the family income above Medicaid-eligibility levels.

Wholesale Acquisition Price - The factory charge, before discounts to wholesalers.